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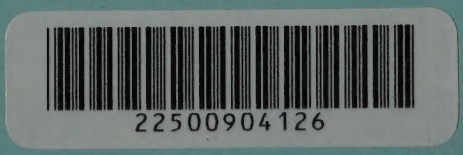
A Report on the Purpose and Activities of the Trust

1939–1948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NUFFIELD PROVINCIAL
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A Report
on the Purpose and Activities
of the Trust
1939–1948

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I

INTRODUCTION

THE NUFFIELD PROVINCIAL HOSPITALS TRUST was established by Lord Nuffield in December 1939 with an endowment of one million share units in Morris Motors, Ltd. The purposes of the Trust, in the words of its trust deed, are:

> the co-ordination on a regional basis of hospital and ancillary medical services throughout the Provinces and the making of financial provision for the creation carrying on or extension of such hospital and ancillary medical services as in the opinion of the Governing Trustees are necessary for such co-ordination.

The intention of this report is to set out as briefly as possible the ways in which the Trust has assisted to bring about the co-ordination of hospital services in the conditions which existed before the coming into operation of the National Health Service Act, 1946, and how it proposes, now that the National Health Service is in being, to continue its work.

The trustees have been guided and greatly helped in their work by their administrative and advisory councils; the Regionalization Council of the Trust, whose first chairman was Mr. S. P. Richardson, J.P., succeeded by Sir George Martin, K.B.E., J.P.; the Medical Advisory Council, formerly under the chairmanship of the late Sir Farquhar Buzzard, Bt., K.C.V.O., D.M., F.R.C.P., and now under that of Sir Ernest Rock Carling, F.R.C.S., F.R.C.P.; and the Women's Advisory Council, under the chairmanship of Lady Norman. For Scotland there is a Scottish Advisory Committee (chairman, Sir Robert Nimmo, J.P.) with its own Medical Advisory Committee (under the chairmanship of Dr. A. Greig Anderson, M.D., F.R.C.P.) and corresponding bodies have also been set up in Northern Ireland, under the

chairmanships respectively of Sir David Lindsay Keir and Dr. F. P. Montgomery, M.C., M.B., CH.B.

The Trust lost, through retirement or death, the guidance and counsel of a number of its original trustees. Among the first trustees, appointed in 1939, were Mr. Lawrence Bland (died 1941), Sir Farquhar Buzzard (died 1945), Alderman Sir William Jenkins (died 1944), Alderman E. G. Rowlinson (died 1941), Sir Charles Herbert Smith (died 1941), The Rt. Hon. Thomas Johnston, P.C. (retired 1941), The Rt. Hon. Lord Woolton, P.C. (retired 1947). The Rt. Hon. Tom Williams, P.C., M.P., appointed in 1941 in the place of Alderman Rowlinson, retired in 1948. Mr. Arthur Jenkins, M.P., appointed in 1945 in succession to Sir William Jenkins, died in 1946.

The Trust owes a great debt to the late Alderman William Hyde, C.B.E., J.P., who, as secretary from 1939 to 1943 and as a governing trustee from 1943 until his death in 1945, devoted himself untiringly to the betterment of hospital services and to the promotion of the purposes of the Trust.

In the eight years ended 31st March 1948 the Trust expended £618,770 on the hospitals and health services in the Provinces. Of this total, the cost of the Trust's Medical Advisory Council and Women's Advisory Council amounted to £8,343 and £1,116 respectively, and the organization of the hospital co-ordination scheme (including the expense of the Regionalization Council) cost £3,891; administrative grants to Regional and Divisional Councils totalled £32,328. The cost to the Trust of the surveys of hospital services (undertaken in conjunction with the Ministry of Health and published as Blue Books by H.M. Stationery Office) was £8,257. Grants for hospital and ancillary services totalled £564,835.

II

THE WORK OF THE TRUST UP TO 5 JULY 1948

1. THE HOSPITAL CO-ORDINATION SCHEME

THE BACKGROUND AGAINST WHICH THE TRUST STARTED ITS WORK

WHAT was the background against which the Trust set to work? Upon what kind of experience could it draw? What efforts had been made in the past, what difficulties encountered, what progress achieved? The idea of a co-ordination of hospital services was not a new one, but, so far, the attempts made to translate it into action had come to very little.

As far back as 1919 the report of the Consultative Committee on Medical and Allied Services (appointed by the Ministry of Health under the chairmanship of the late Lord Dawson of Penn) had advocated the amalgamation of municipal and voluntary agencies as the basis of a scheme for the establishment of health authorities whose task it would be to administer locally all forms of medical service. Later, both the Voluntary Hospitals ('Cave') Committee, set up by the Ministry of Health, and regional committees established by the British Hospitals Association, attempted to bring about closer relations between the voluntary hospitals of given areas. Section 13 of the Local Government Act, 1929 (later repealed by the Public Health Act, 1936), gave for the first time statutory expression to the need for co-operation between voluntary hospitals and local authorities. The Public Health Act, 1936, made it obligatory for a local authority, when making provision for hospital accommodation, to consult a committee or other body representative of the governing bodies and the medical and surgical staffs of the voluntary hospitals in the area.

The year before this Act was passed the British Hospitals Association appointed the 'Sankey' Commission. This commission recommended (i) the division of the country into hospital regions, (ii) the formation of voluntary hospital regional councils to correlate hospital work and needs in each region, and (iii) the setting up of a voluntary hospitals central council to co-ordinate the work of the regional councils. A provisional council was appointed to decide how these recommendations might be put into effect, but it was hampered by lack of funds, and even more by the realization that a full co-ordination of hospital and ancillary medical services was impossible without the co-operation of public health authorities. Even within the voluntary hospital field the efforts of the provisional central council met with little success, and progress towards co-operation between voluntary hospitals and local authorities, except in a few areas, was still more limited. Voluntary and municipal hospitals were competitive rather than complementary.

This was the situation when the Provincial Hospitals Trust was formed by Lord Nuffield in the hope that, in course of time, a truly national hospital service might be evolved '. . . which would embrace all that is best of both public and voluntary effort, with the maximum of economy to the State and to the private purse'.

THE TRUST'S PLAN FOR REGIONAL CO-ORDINATION

Demarcation into regions and creation of regional and divisional councils

The Trust set out to establish advisory machinery which it hoped would bring together in a full partnership, yet without prejudice to the individuality of each, the various hospitals within a given area. The areas suggested for the regions corresponded roughly to the regions since established under the National Health Service Act, and were, in turn, subdivided into hospital divisions.

In view of later happenings—the more extreme form of hospital regionalization introduced by the National Health Service Act—there is little point in detailing here the nature of the plan on which the Trust took action. The scheme is fully described in a memorandum on the co-ordination of hospital services, published in 1941,[1] and for purposes of historical record the relevant sections outlining the plan are attached to this report as Appendix 1. The basis of the plan was the demarcation of the country into a series of hospital regions, each having as the focus of the hospital and health services a university medical school and a 'key' hospital. The regions were divided into hospital divisions, each with a main hospital at the core to which the smaller hospitals and clinics of the division were linked. In turn the main divisional hospitals were linked to the regional key hospital. Ambitious and pioneering in spirit, the plan can be said to have helped to form opinion in this country and to have exerted an influence on hospital planning as far afield as the United States.

The original plan to establish a series of regional and divisional advisory councils covering the country was not carried through. The Government, following its announcement of post-war hospital policy in 1941, and after consultation with the local authorities, asked the Trust to suspend further action to avoid administrative and other difficulties. Since the Trust's only concern was to improve the nation's health and hospital services it felt bound to respond to this request and, in this manner, one side of its activities came to a partial halt. The scheme had, by this time, provided for four regional and eleven divisional councils in England and Wales. In Scotland an advisory committee on the regionalization of hospital services and a medical advisory committee had been established. A regional hospitals council for Northern Ireland was formed in 1942. Sometimes,

[1] *A National Hospital Service, A Memorandum on the Co-ordination of Hospital Services* (Nuffield Provincial Hospitals Trust, 1941).

as shown in Appendix 2, there was a region without a division, elsewhere a division without a parent region, mainly because, from the administrative point of view it was easier to begin in one place on divisional lines, in another to start at the top. Where the setting up of a new council would have meant an unnecessary duplication of administrative machinery the Trust used in its plan—side by side with the new councils it had formed—existing hospital councils such as the Manchester, Salford, and Stretford Joint Hospitals Advisory Board. The tasks set to the regional and divisional councils were varied, yet at the same time they all conduced to the same end: 'to achieve in every possible way the aim of raising the standard of service to the patient throughout the region.' The search for co-ordination was never pursued in the interests of administrative convenience but always as a means of ensuring that the patient might find in his own area a good service and a complete service.

By the time the National Health Service became a fact the Trust's regionalization scheme had reached the stage where about half the country possessed active advisory hospital councils of one kind or another. Some of these are still in existence, others closed down on the introduction of the new statutory scheme. Although, by force of circumstance, the Trust had not been able to complete its experiment, it can fairly claim to have provided a practical demonstration—over a number of widely different areas and for a period long enough to be valuable—of the way in which a joint advisory council can help to co-ordinate and improve the health and hospital services of an area. Again, by its extensive surveys—with their discovery of deficiencies and their plans, often of a long-term nature, to remedy them—the Trust has presented the new statutory bodies with a solid background of facts against which to build. But perhaps the greatest contribution which the Trust has made is in educating men to think in terms of a complete hospital service for an area where

formerly they had thought only in terms of an individual hospital working largely in isolation. The Trust brought around a common table, to consider area needs, men and women with an intimate knowledge of voluntary hospitals, local authority experts engaged on municipal hospital problems and public health work, doctors, and laymen. Not only did those familiar with one type of hospital begin to understand the other's difficulties but, more important still, they prepared themselves to take part in a comprehensive and co-ordinated service. Many members of the Trust's advisory councils are now members of the various administrative bodies of the National Health Service.

THE SURVEYS OF HOSPITAL SERVICES

From the start of its activities it had been clear to the Trust that it would not suffice to set up regional and divisional councils and to rely upon a better, or even a very good, understanding between local authority and voluntary hospital representatives to bring about a better co-ordination of the various parts of the hospital service. For one thing, even the most friendly rivalry was not what was wanted. But, more important, nobody knew whether, if the various parts of the service were dovetailed together, completeness would be achieved. It seemed fairly certain there would be some gaps in the jigsaw; the first need was to discover their nature and their whereabouts. A survey of hospital services in a given area was the obvious answer and, at the suggestion of the Trust, the regional and divisional hospital councils had provided in their constitution for the making of such surveys.

The Trust had already made three surveys of hospital services—in Cornwall, in Devon, and in Bristol—when, in 1941, the Government announced its intention of instituting a series of surveys, starting with London and the surrounding area, to provide the information needed as a basis for future plans. The

Trust thereupon offered to undertake the organization and financing of the provincial surveys—an offer which was welcomed by the then Minister of Health, the Rt. Hon. Ernest Brown. It was agreed that the surveys made by the Trust and those made by the Ministry should proceed after the same plan and, accordingly, all the survey teams were given the same terms of reference:

> to survey the Hospitals (other than mental hospitals and mental deficiency institutions) in the Counties of . . . and having regard to the information thus obtained, and to the general principles of post-war policy laid down by the Minister of Health in the House of Commons on 9th October 1941, to advise the Minister what modifications or developments of the existing hospital facilities would be necessary or desirable to give effect to that policy.

The areas to be surveyed were decided in consultation with the Ministry of Health and the Trust undertook the planning of the seven surveys set out in Appendix 3. The cost to the Trust was £8,257.

The ten teams—three appointed by the Ministry and seven by the Trust—naturally found good things here and deficiencies there in the varying conditions of widely different areas. Yet there was a unanimity as monotonous in detail as it was startling in cumulative effect in the final conclusions of the reports that the three main defects of the hospital service were: (i) inadequate accommodation, (ii) shortage and maldistribution of consultants and specialists (because of necessity they were concentrated in the places in which it was possible to build up an adequate private practice), and (iii) lack of co-ordination.

The reports of the surveys were printed and published as Blue Books by H.M. Stationery Office.[1] Their undeniable value, in

[1] *Hospital Survey* (London: H.M. Stationery Office, 1945). London and Surrounding Area, 10*s.*; Berks., Bucks., and Oxon., 5*s.*; Eastern Area, 2*s.* 6*d.*; South-western Area, 10*s.*; South Wales and Monmouthshire, 5*s.*; Sheffield and East Midlands Area, 7*s.* 6*d.*; West Midlands Area, 5*s.*; Yorkshire Area, 5*s.*; North-western Area, 10*s.*; North-eastern Area, 5*s.*

that whatever future hospital policy might be decided upon they provided the first and only national statement of present conditions, prompted the Trust to publish a summary of the conclusions reached by the ten teams of surveyors on a service the chief fault of which lay in its lack of a system. This pamphlet[1] succeeded in its intention to pin-point, among the detail of each substantial Blue Book, the criticisms and suggestions that were of national application, and, in so doing, 'to demonstrate how wide is their agreement'.

Northern Ireland

A survey of the six counties of Northern Ireland is in a somewhat different category from those already mentioned. Directly sponsored and financed by the Trust, the surveyors were given the following terms of reference:

> to survey the Hospitals including mental hospitals and mental deficiency institutions in Northern Ireland, and, having regard to the information thus obtained, to advise the Northern Ireland Regional Hospitals Council through the Trust what modifications or developments of existing hospital facilities would be necessary or desirable to give effect to a co-ordinated and comprehensive hospital service.

It will be noticed that mental hospitals and mental deficiency institutions, excluded from the English surveys, were brought within the scope of the Northern Ireland survey.[2]

PLANNING OF AREA HOSPITAL SERVICES

Apart from the big regional surveys made by the Trust, many of its associated councils set up special committees to survey existing hospital services within their areas, and some of the resultant reports on individual problems are of more than passing local interest.

[1] *The Hospital Surveys, The Domesday Book of the Hospital Services* (Nuffield Provincial Hospitals Trust, 1946).

[2] *Survey of the Hospital Services of Northern Ireland* (Nuffield Provincial Hospitals Trust, 1946).

England

The Medical Services Committee of the *Yorkshire Regional Hospitals Council* produced, in June 1944, a report[1] which stands apart from previous survey reports sponsored by the Trust in that it was compiled in a different, many-sided way, and from an unaccustomed angle. The Medical Services Committee of this Council concluded that the approach to a new organization of hospital services should be clinical, and at the same time decided that, since modern medicine was made up of so many specialties, it was not, as a body, qualified to pronounce on policy or to make plans without further specialist advice. It therefore set up sixteen sub-committees to consider the principal specialties, each sub-committee being composed of members of the consulting staffs of municipal and voluntary hospitals, representatives of local authorities and general practitioners, with the addition of experts co-opted from outside the region to give their views on certain specific points. The reports of the sixteen sub-committees were issued in the one volume, and requests for copies have come from many parts of the world.

The Essex Hospitals Joint Advisory Council was set up in 1945. The report of the surveyors of the hospital services of London and the surrounding area (which included Essex) had then been issued, and the Council brought together a survey sub-committee to consider the implications, in Essex, of the surveyors' report and to advise on the problems involved. In their discussions the sub-committee had the benefit of knowing not only the principles contained in the National Health Service Act, 1946 (including the intention to create management committees for groups of hospitals), but also the delimitation of the area of the proposed North-East Metropolitan Regional Hospital Board. The report[2] of the sub-committee, issued by the Trust in 1947,

[1] *Interim Report of the Medical Services Committee of the Yorkshire Regional Hospitals Council* (Nuffield Provincial Hospitals Trust, 1944).

[2] *Report of Survey Sub-Committee of Essex Hospitals Joint Advisory Council* (Nuffield Provincial Hospitals Trust, 1947).

contains an up-to-date revision of the factual material relating to the geographical county of Essex which had been included in the London surveyors' report, and also suggestions for the improvement of hospital services in the area, recommendations for the future grouping of hospitals, and comments on the London surveyors' recommendations.

The Council set up also a cancer sub-committee to consider and make recommendations about the establishment of a comprehensive cancer scheme for Essex with a view to the submission of recommendations to the local authorities concerned. The report of the cancer sub-committee, outlining a scheme to provide facilities for the diagnosis and treatment of cancer, was issued as Appendix C of the survey sub-committee's report.[1]

The Surrey Hospitals Divisional Council brought out, at the end of 1945, a plan for the co-ordination and extension of existing hospital services in their area.[2] The report gives an account of existing hospital facilities and includes a plan for a structure on which a comprehensive hospital service could be built in and around the county of Surrey and the county borough of Croydon.

Under the *Berks., Bucks., and Oxon. Regional Hospitals Council* a number of special sub-committees were appointed to consider such questions as the provision and organization of regional services for the acute and chronic sick and for such specialties as pathology, ophthalmology, orthopaedics, maternity, cancer, and psychological medicine, and the formation of a regional accident service; their findings and recommendations were summarized and published in one volume[3] in January 1947. The most recent of these special committees was appointed

[1] Ibid.

[2] *A Plan for the Co-ordination and Extension of Existing Hospital Services within the Area of the Surrey Hospitals Divisional Council* (Nuffield Provincial Hospitals Trust, 1945).

[3] *Report on the Planning of Hospital Services in the Berks., Bucks., and Oxon. Region* (Nuffield Provincial Hospitals Trust, 1947).

in 1947 to conduct a survey of the child health services of the area. This report,[1] published in 1948, was widely commented upon. It was generally felt that the picture drawn of the facilities then available in the Berks., Bucks., and Oxon. Region and the measures suggested to improve the child health services in the region were of more than local interest and applicability.

Scotland

Three reports have been issued by the Medical Advisory Committee of the *Scottish Advisory Committee* of the Trust. The first,[2] published in 1941, was general in character, discussing problems of the hospital services and the advantages which might be derived from the correlation of medical services on a regional basis. The next report,[3] published in 1943, dealt with hospital staffing in all its aspects; hospital admissions and the maintenance of records; transport; hospital planning and design. The third report,[4] issued in 1946, outlined the committee's view on health services for university students, the care of the chronic sick, standards of hospital services, and the hospital almoner, and also gave an account of the Glasgow Bureau of Health and Sickness Records.

Northern Ireland

In August 1946 the *Northern Ireland Regional Hospitals Council* published its plan for the hospital services of Northern Ireland.[5] Following the survey of hospitals in the Province, already referred to on page 17, the Council set up a co-ordination committee and fourteen sub-committees. Their reports

[1] *Child Health Services* (Nuffield Provincial Hospitals Trust, 1948).

[2] *Preliminary Report of Sub-Committee on Medical Services* (Nuffield Provincial Hospitals Trust, 1941).

[3] *Interim Report of Medical Committee of the Scottish Advisory Committee* (Nuffield Provincial Hospitals Trust, 1943).

[4] *Second Interim Report of Medical Committee of the Scottish Advisory Committee* (Nuffield Provincial Hospitals Trust, 1946).

[5] *The Red Book, A Plan for the Hospital Services of Northern Ireland* (Northern Ireland Regional Hospitals Council, 1946).

were 'made available to the people of Northern Ireland as being the best foundation for a properly co-ordinated hospitals service of the future'. The plan was extensive; it included proposals for the development in Belfast of a 'key' hospital centre for the Province, the establishment of nine Provincial hospitals of the order of 500 beds each, the basing of the psychiatric services upon a Central Institute of Psychiatry and the mental hospitals, and the erection of general practitioner clinics. It also dealt with many other matters, such as child health, tuberculosis, special and ancillary services, and staffing.

HOSPITAL INQUIRIES

From time to time, at the request of their boards of management, the Trust has made confidential inquiries into the administration and services of a number of hospitals in different parts of the country. In each case the part the hospital should play within a co-ordinated scheme has been thought to be at least as important as the merits and demerits of the services provided by the hospital. In several cases the inquiry was undertaken as a preliminary to consideration of an application for grant from the hospital concerned, and was followed by the making of a grant.

ACCIDENT SERVICES, FRACTURE, AND ORTHOPAEDIC UNITS

This is perhaps an appropriate place to mention the report of the Medical Advisory Council of the Trust on accident services (incorporated in the memorandum on the co-ordination of hospital services[1]), although it is of a different nature and has an entirely different topic from those already referred to. The Council felt that the practice then existing, whereby the treatment of patients in the casualty departments of hospitals was left largely in the hands of junior and recently qualified medical

[1] *A National Hospital Service, A Memorandum on the Co-ordination of Hospital Services* (Nuffield Provincial Hospitals Trust, 1941), pp. 19–21.

officers, was unsatisfactory. They commented that 'on the whole, treatment of major injuries has been efficient, but the treatment of minor injuries leaves much to be desired. A wound of the finger may throw a man out of work for two or three months, whereas with efficient treatment from the start, healing may take place in a few days.' They were of the opinion that an accident service organized regionally was necessary for the whole community and recommended that such a service should be designed to treat fractures, joint injuries and their complications, lacerations and contusions, burns and scalds, and sepsis resulting from injury.

As a result of the conclusions reached by the Council the Trust made various grants towards the establishment and improvement of accident services. For example, a grant of £2,500 was made to the Radcliffe Infirmary, Oxford, for the equipment and adaptation of accommodation necessary for the development of an accident service, and a grant of £4,000 was made to the Birmingham Accident Hospital.

2. SOME PROJECTS SUPPORTED BY THE TRUST TOWARDS THE BETTER CO-ORDINATION OF HOSPITAL SERVICES

THE TRUST'S POLICY ON THE MAKING OF GRANTS

THE making of the hospital surveys might be likened to the stretching of a tapestry upon a frame: it showed up equally the good strong fabric, the weak, threadbare, and cobbled patches, and the holes. It was never the intention of the Trust to sit back at this stage and leave it to others to remedy defects. The Trust felt bound both to seek a better ordering of the various services then existing and also, and equally important, to try by positive means to improve specific parts of the services and to encourage new developments.

The income of the Trust was applicable (*a*) to carrying into effect and administering the Trust's co-ordination scheme for hospitals, (*b*) to making grants for the establishment, extension, or maintenance of voluntary hospitals and ancillary medical services throughout the provinces, and (*c*) to advancing co-ordination by any other means the Governing Trustees thought fit.

At the start the Trust supplied its various regional and divisional councils with annual sums for administrative purposes, and also allocated yearly to each council a sum known as a block grant. These block grants, which were used for miscellaneous purposes—generally as grants to individual hospitals —were discontinued in April 1945, their purpose having been largely achieved.

Apart from the block grants and annual expenses grants, the Trust has, since its start, devoted a part of its funds to projects of a wider nature, in each of which it sought to foster the spirit of co-ordination between municipal and voluntary hospitals, local authorities, and universities.

In developing their grant policy the trustees decided that, as a general principle, they would support only one project in a particular field and that their aid should be directed, wherever possible, towards projects which might be described, if not as frankly experimental, at least as giving a lead. Thus it was not the practice to authorize subventions for the carrying on of existing hospital services, or to supplement the income of hospitals or to reduce deficits on maintenance accounts. In 1945 (at the same time that the block grants were discontinued) the Trust felt that it had reached a stage when a wider view should be taken of projects which might be supported. At about the same time the decision to make the general policy of the Trust complementary, so far as possible, with that of the Nuffield Foundation (which had been created by Lord Nuffield in 1943) began to take effect. As a result the trustees agreed that the three following considerations should largely govern their choice of schemes for support:

(*a*) The scheme should aim at the application or extension of knowledge likely to lead to the promotion of social welfare and to the co-ordination of health services.

(*b*) It should provide the opportunity for a practical demonstration of an accepted theory, and by so doing lead the way to some development in preventive or remedial medicine able to command widespread interest and support from Government, university, local authority, or voluntary bodies.

(*c*) The scheme should be associated, whenever appropriate and possible, with an individual of outstanding capacity and personality to direct and guide its development.

Grants have been made to a number of projects which the Trust regards as experimental. Support has been given for a limited period in the hope that, where the result was sufficiently promising, the schemes would receive continuing financial

assistance from sources other than the Trust. The field covered by the Trust's programme has been diverse, and the projects to which it has given support range from university chairs in social medicine, psychiatry, and child health to the organization of experimental refresher courses in hospital catering.

SOCIAL MEDICINE

The general recognition of the importance of what is termed 'social medicine', the sudden and rapid progress which is being made in a branch of medicine whose boundaries are not yet clearly defined, incline to make us forget how very recent indeed is the establishment of university chairs and departments in this subject.

It was only six years ago, in 1942, that the Trust provided £100,000 for the creation of the first Professorship and Institute of Social Medicine in Great Britain. This Chair and Institute were established at the University of Oxford: Professor J. A. Ryle, M.D., F.R.C.P., was appointed to the Chair and became the first Director of the Institute. The trust also made a grant of £15,000 to the University of Birmingham towards the cost of establishing a like professorship there: the first occupant of this Chair is Dr. T. McKeown, M.D., PH.D., D.PHIL., who was appointed in 1945.

The Chair and Institute of Social Medicine, University of Oxford

The purposes of the Institute are defined as:

(i) to investigate the influence of social, genetic, environmental, and domestic factors on the incidence of human disease and disability;

(ii) to seek and promote measures, other than those usually employed in the practice of remedial medicine, for the protection of the individual and of the community against such forces as interfere with the full development and maintenance of man's mental and physical capacity;

(iii) if required by the University to do so, to make provision in the Institute for the instruction in Social Medicine of students and practitioners of medicine approved by the Board of the Faculty of Medicine in the University of Oxford.

Owing to war-time difficulties, and in particular to shortage of staff and equipment, the active work of the Institute did not start until the spring of 1943. Since then both its research and teaching work have grown steadily, together with its reputation. A comprehensive account of the work undertaken by the Institute is contained in its three Annual Reports for 1945, 1946, and 1947.

Here there is space to mention only a few of the varied investigations conducted by the Institute under the three main heads of:

(i) the beginnings of life (i.e. in the antenatal phase, infancy, and childhood), adolescence, and young adulthood;

(ii) occupational sickness and accidents;

(iii) morbidity and mortality of certain prevalent diseases.

Under the first head a study of the geographical distribution and trend of the stillbirth rate in England and Wales in relation to social factors is now complete and is likely to be published shortly. A long-term child health survey, studying and comparing the health, development, and sickness-experience of children in all social groups from the first week of life up to 5 years of age has been in progress for nearly four years. Other investigations include a pilot survey of forty-two pairs of twins at school-age, completed with the assistance of the Oxford City Education Authority; a study of the effects of rest preceding confinement in working-class women; and a radiographic investigation on groups of children, both English and Dutch, to discover evidence of nutritional deficiencies and other abnormalities, and also to obtain information on the range of

variability within the 'normal' at different years in the period of growth.

Inquiries into occupational sickness and accidents—the second of the three heads—range from a general survey of sickness-absenteeism in a factory to an inquiry into the reported high incidence of tuberculosis in the Northamptonshire boot and shoe trade.

Under the third and last head of morbidity and mortality of certain prevalent diseases the Institute has made studies of the morbidity of pulmonary tuberculosis, of the social and occupational factors in the aetiology of skin-cancer, and of the mortality and morbidity of appendicitis.

On the teaching side the Director of the Institute has undertaken from the beginning of the academic year 1946–7 the organization of all teaching in social medicine and public health for medical students of the University of Oxford during their clinical training. For the last academic year social science students of the University have also been admitted to the lectures. Although official postgraduate courses have not yet been arranged the Institute provides facilities for a small number of qualified research assistants to work there.

The activities of the Institute extend beyond research in so far as it acts as a centre at which people interested in the many sides of social medicine can meet and discuss their common problems. The Institute has established close co-operation with the scientific departments of the university, with staffs of the hospitals in the area, and with the public health departments of the city and county of Oxford, medical and welfare departments elsewhere, factory managements, and education authorities.

Health and sickness records

One interesting development in social medicine which has been sponsored by the Trust on the suggestion of its Medical

Advisory Council is the creation of two experimental bureaux of health and sickness records. The Council proposed that one such bureau should be located in a rural area containing an urban centre, and the other in a thickly populated and highly industrialized area. As a result one was established in Oxford, the other in Glasgow. Since 1943 the Trust has provided £51,450 for these bureaux.

The two bureaux were given the same, rather formidable, terms of reference:

(*a*) To collect (from all accessible sources) and synthesize records of events of medical significance affecting the inhabitants of a selected area within the Region, and to use the information thus obtained for investigating morbidity in relation to sex, age, social class, environment, and other factors.

(*b*) To publish from time to time statistical tables, &c., which it is hoped will be of value to investigators studying problems of health and sickness, and especially to those concerned with the control and planning of hospital services.

(*c*) To test, by experiment, the practicability of a larger scheme for registering health and sickness information with the double aim of providing morbidity statistics and of producing authentic medical case-histories.

(*d*) To fulfil, so far as possible, an educational function, by encouraging the adoption of standardized forms of record, more particularly in hospitals.

It is interesting to see how each bureau has attacked its task in a rather different way.

Part of the resources of the Oxford bureau have been devoted to a vast and continuing collection and tabulation of in-patient records of the twenty-five hospitals in the Oxford area. Outside this general and long-term project—the material is under

examination and study—the Oxford bureau has rendered services of many kinds to, among other bodies, the Trust itself, the Nuffield Foundation, the Oxford Institute of Social Medicine, the Medical Research Council Pneumokoniosis Unit, the Berks., Bucks., and Oxon. Regional Hospitals Council, and local authorities. For instance, the bureau has helped the Survey Committee of the Foundation appointed to study the problems of ageing and the care of old people, and has co-operated in various research projects undertaken by the Institute, notably in the child health survey, and in the statistical studies of the causes of occupational sickness. It has also helped hospitals in and around Oxford, as well as farther afield, by supplying them with data relating to particular diseases, injuries, and population groups.

The Oxford bureau has carried out the last clause in its terms of reference by helping a number of teaching hospitals in different parts of the country with information and advice on methods of hospital record keeping. A course conference, lasting eight days, was organized by the bureau in September 1947 and was attended by over 100 delegates, including clinicians and administrators as well as records officers.

The Glasgow bureau, which came into being in the early summer of 1943, devoted itself, for the first eighteen months of its existence, to an inquiry of a specialized character, with the intention of widening its scope at a later stage. This inquiry, directed by Professor C. F. W. Illingworth, C.B.E., M.D., F.R.C.S. (ED.), F.R.F.P.S., was in two parts: (*a*) an attempt to determine the frequency and incidence of ulcer-perforation in the population of the West of Scotland, and (*b*) a detailed clinical follow-up study of patients treated in the Western Infirmary, Glasgow. (Incidentally, the inquiry having shown that there were 40,000 persons in the area under review suffering from peptic ulcer, a special clinic was set up at the Western Infirmary—the Trust contributing towards the initial cost—to study the

causes of peptic ulcer and the exploration of new methods of treatment.)

Since the end of the war the work of the Glasgow bureau has begun to develop on broader lines. A report has recently been published of an investigation, started in October 1946, into the nature and amount of hospital-treated sickness among the population of Stirlingshire.[1] A somewhat similar survey is being conducted in Ayrshire. Other investigations in progress include a study of the after-history, with special reference to employment, of 800 to 900 mentally retarded children who had attended a pioneer special school in Paisley, and a survey of the subsequent medical, social, and economic history of 1,400 boys who, in January 1947, left elementary schools in Glasgow at the age of 14.

Student-health services

The Trust has taken a particular interest in one special aspect of social medicine, the health of the university student, to which it is true to say that, until quite recently, little attention has been given.

The Report of the Inter-Departmental Committee on Medical Schools, published in 1944, stated: 'We hold the view that Universities have responsibilities in respect of the health of their students, and that for the fulfilment of their responsibilities each should provide a properly organized Student Health Service.' A similar view was also expressed by the Social and Preventive Medicine Committee of the Royal College of Physicians. Lately a number of medical schools and universities have begun to provide limited facilities for the care and supervision of the health of their students.

In July 1947 the Trust sponsored a conference on student health. The conference was held at the Institute of Social Medicine, and was attended by representatives of universities

[1] *Hospital and Community;* I. *Hospital-treated Sickness Amongst the People of Stirlingshire* (Nuffield Provincial Hospitals Trust, 1948).

throughout Great Britain and Northern Ireland. This was the first time that delegates from universities, university colleges, and medical schools had met together to discuss the health of students and to pool their knowledge and experience. One outcome of the discussions was the publication of a memorandum based on the findings of the conference and advocating the setting up of student-health services in every student centre. Copies were sent to all Vice-Chancellors, heads of University Colleges, and Deans of Medical Schools.

INDUSTRIAL HEALTH

The gap that divides social medicine from industrial health is so easily bridged that it seems logical to pass on from a review of the contribution made by the Trust in the field of social medicine to a mention of its grant to the Slough Industrial Health Service.

The Slough Industrial Health Service has three chief aims: first, to attempt to solve the practical problem of how small firms which cannot afford to employ medical and nursing staff of their own may secure the benefits of a comprehensive industrial health service for their employees; second, to test the value of a scheme in which measures for the promotion of health and the study of the preventive side of industrial health are undertaken by the same staff as are concerned with the rehabilitation and re-training of the disabled; and third, to provide a field station for teaching and research in industrial health and related problems.

The Slough area is a particularly suitable one for the experiment in that it contains over 300 firms engaged in a wide variety of trades and industries, most of which employ less than 50 workers. It also lends itself, as a highly industrialized town in a rural setting, to a widening of the experiment so as to include agricultural as well as industrial workers—a development which it is hoped may be possible once the Service is fully established.

The Service consists of two main parts, a central industrial health and accident clinic in buildings forming part of the Slough Community Centre, and a recuperative home just over a mile away at Farnham Park. The central Clinic started work on 1st May 1947. By the end of the month 52 firms, with 6,324 employees, had joined the Service, and within 12 months this figure had increased to 99 firms and 10,849 workers. The Clinic includes the following departments: reception, treatment, resuscitation, and examination; X-ray; physiotherapy; chiropody; orthopaedic; records and administration; and it also comprises ambulance posts, first-aid posts in member firms, a mobile dressing-station, and accident services.

Farnham Park was opened as a recuperative home on 1st October 1947 with accommodation for 47 patients. The capacity of the home will be increased as and when buildings can be adapted. It is not a convalescent home in the ordinary sense of the term but a centre where active rehabilitation can be carried out to restore patients to full earning-capacity, or, in the case of the permanently disabled, to such earning-capacity as their disability allows. Patients are admitted at the request of industrial firms, hospitals, and members of the medical profession, so long as the case is one which, in the Medical Director's opinion, is likely to benefit by treatment in the Centre. A proportion of the beds are reserved for cases from the Slough area but the interest and support of hospitals and firms over a wide area has already been evoked and certain of the London teaching hospitals have been quick to recognize the advantages which a home of this type can offer in the rehabilitation of suitable cases.

The Trust made grants totalling £25,000 to the Service because it recognized that the experiment was one likely to provide the community with the practical experience it still lacked on the organization of health arrangements in industry, and which, when fully developed, might serve in part or as a whole as a model for like services in other parts of the country. Indeed it

may prove a valuable guide in the planning and development of a national industrial health service should the Government decide, in time, to introduce such a service as a part of, or complementary to, the National Health Service.

The Trust also welcomed the chance of showing how profitably an ancillary service can link up with the other parts of the health and hospital services. In this aim it has not been disappointed and the relations now established between the Industrial Health Service on the one hand, and the hospitals, general practitioners, and other health agencies in the Slough area on the other, are not only cordial in the accepted phrase but of proven benefit the one to the other.

CHILD HEALTH

A memorandum[1] prepared by its North-Eastern Regional Hospitals Advisory Council in 1942 first drew the Trust's attention to the state of paediatrics in the country, and led it to consider the part which universities and teaching hospitals should play in the promotion and study of child health. The Medical Advisory Council of the Trust agreed with the authors of the memorandum in thinking that the teaching of paediatrics in university medical schools was a subject of great clinical, scientific, and sociological importance, which at that time was receiving inadequate support and attention. The Council's view is one which, gradually, has become more and more general, and which found very definite expression in the recommendation of the Inter-Departmental Committee on Medical Schools that a department of child health under a whole-time professor should be considered essential in a university medical school.

The Medical Advisory Council, in recommending that grants from the Trust's funds might profitably be devoted to the establishment of paediatric units of teaching and research in university

[1] *Paediatrics in Universities and Teaching Hospitals* (North-Eastern Regional Hospitals Advisory Council, 1942).

medical schools, emphasized that their value would be all the greater if they not only served as centres of teaching and research but also were so placed—and staffed—that they were able to co-operate with neighbouring hospitals and local authorities and take an active part in local authority schemes for the promotion of child health and welfare.

The Trust counts itself most fortunate in that Professor J. C. Spence, M.C., M.D., F.R.C.P., was appointed to be the first holder of the Chair in Child Health which it established at *King's College, University of Durham*, in 1942. It is impossible in a document of this kind to attempt to summarize the work of Professor Spence's department even though it has not been very long established; it is an admirable example of a university department working closely and in a spirit of friendliness with the hospitals and public health services of the area. The Trust's initial grant towards the establishment of the Chair was £15,000 to be spread over a period of ten years; in 1947 a capital grant of £14,500 was made for expansion of the work of the department.

The other substantial grant (£30,000) which the Trust made in the field of child health was towards the establishment, in March 1948, of a Chair and Department of Child Life and Health at *Queen's University, Belfast*. Professor F. M. B. Allen, M.D., F.R.C.P., has been appointed to the Chair. It is too early to make any comment on this project but the Trust is satisfied that the Chair and Department are being established in a favourable atmosphere, and that there is an excellent prospect of realizing a well-integrated child health service in Northern Ireland. The fact that the Professor and head of the Department has been appointed Adviser on Child Health to the Government of Northern Ireland and to the Corporation of Belfast is a clear pointer towards the development of a complete service to include not only the hospitals associated with the University as teaching hospitals but also other hospitals, having childrens' wards,

throughout the six counties, as well as the child welfare clinics of the local authority.

The Department of Child Life and Health of the University of Edinburgh has been helped by the Trust in carrying out research in infant dietetics, including breast-feeding. Other small grants in the same field include a grant to the Glasgow Royal Maternity Hospital for the salary of a dietitian for the hospital wards and ante-natal clinics, and a grant to the University of Bristol for an investigation into the treatment and prophylaxis of acute rheumatism in childhood. A clinic for the study and treatment of rheumatism in children has been set up at the Belfast Hospital for Sick Children. For the various studies and projects referred to in this paragraph the Trust has made grants totalling nearly £10,000.

MENTAL HEALTH

Social medicine, child health, and psychiatry were all mentioned by the Inter-Departmental Committee on Medical Schools as aspects of medicine to which, in future, the medical teaching centres would need to devote more attention. We have shown the contribution made by the Trust in the first two of these fields. It has also interested itself in psychiatry, seeing in Leeds an opportunity to set up a co-ordinated psychiatric service which would, the Trust hoped, bring about close associations between the University, the voluntary hospitals, and the municipal health services, and which, if it developed successfully, might become a pattern to be followed by other regions. A grant of £15,000, over six years, was made to the *University of Leeds* towards the expenses of a whole-time Chair of Psychiatry and a complete psychiatric unit. The plans for the unit were ambitious. They included the provision of facilities for both undergraduate and postgraduate work and for research, as well as for the treatment of patients suffering from all forms of

mental illness, from the minor forms of psycho-neurotic disorders to certifiable mental disease.

Dr. H. V. Dicks, M.D., F.R.C.P., was appointed in 1946 to be the first holder of the Chair and was succeeded, on his resignation in July 1948, by Professor D. R. MacCalman, M.D. In spite of post-war difficulties in obtaining staff and accommodation which, of necessity, hampered the work at its start, the ground has been prepared, and the foundations laid, for the building up of a psychiatric department suitable to serve the needs of the whole region.

NEUROLOGY

In neurology the Trust found yet another branch of medicine in which it was possible, at one and the same time, to help on the development of the subject, and to further the co-ordination of hospital services, in this case by aiding the establishment of a regional neurological centre involving close liaison between university, local authority, and voluntary hospitals.

In 1943 a grant of £3,000 a year for five years was made to the *University of Manchester* to assist, on a short-term basis, a much-needed extension of the existing service pending the realization of the University's long-term plans for the building of a neurological institute as part of a university hospital centre.

A grant made in 1944 to help the *University of Liverpool* to set up a neurological centre is held in reserve. Post-war difficulties in finding staff and accommodation have prevented the University's plans from developing as quickly as it had hoped. The appointment of a neurological surgeon, deferred until adequate accommodation could be found, now waits on talks to be held between the United Liverpool Hospitals and the Regional Hospital Board to decide the location of the new unit.

Recognizing the extensive and pressing need to provide ex-service men and women suffering from head wounds and their after-effects with the best treatment and rehabilitation measures,

the Trust made a grant of £20,000, over five years, towards the appointment at the *Radcliffe Infirmary, Oxford*, of a medical neurologist who would also supervise the treatment of patients at the Ministry of Pensions Hospital at Stoke Mandeville and would take part in the teaching of neurology in the University. Dr. Ritchie Russell, M.D., F.R.C.P., who worked at the St. Hugh's Hospital for Head Injuries, Oxford, during the war, was appointed to the post, and shortly afterwards instituted at the Wheatley Military Hospital a Head-Injury Bureau to act (i) as an advice centre for those with head wounds, and (ii) as a centre for research. The bringing together of social welfare work with scientific research has proved valuable, the one contributing to the success of the other.

Recent advances in neuro-surgery and chemotherapy greatly reduced the mortality from brain-wounds during the last war. Many men survived who, but for these advances, would have died. Many regained much of their lost brain-function; speech, sight, and mental faculties returned, paralysed limbs recovered their function. But many are still severely disabled and unable to cope with the ordinary conditions of civil life. If they are to make their contribution to the community within the limitations imposed upon them by their disabilities their physical, mental, and vocational capacities for work must be accurately assessed while they are in hospital, and training facilities must be provided for them. This is where, with the aid of a skilled team of workers, the medical neurologist can make a notable contribution by undertaking research into the best forms of rehabilitation and into the many problems associated with head injuries.

REHABILITATION

The war greatly increased the need for plastic surgeons, and, even though the demand is less in times of peace, plastic surgery has a big contribution, both physical and psychological, to make towards the rehabilitation of the injured.

Plastic Surgery Unit, University of Oxford

A grant of £2,000 a year for ten years towards the cost of establishing and maintaining a plastic surgery unit in the University of Oxford was made by the Trust in 1943. Mr. T. Pomfret Kilner, M.B., F.R.C.S., was appointed as first Director of the Unit with the title of Nuffield Professor of Plastic Surgery. The Unit has its headquarters at the Churchill Hospital, Headington, and is being developed as a centre for the training of plastic surgeons, working in close touch with those laboratories of the University in which parallel investigations of biochemical and other problems connected with the growth and repair of tissue, fundamental to plastic surgery, are being carried on. Until now a lack of accommodation has prevented the development of the Unit in accordance with the original plans, but it is hoped that this is a difficulty which will presently be overcome. The Unit is linked to the Radcliffe Infirmary, Oxford, and to the Ministry of Pensions Hospital at Stoke Mandeville.

Department of Education for the Deaf, University of Manchester

By a grant of £3,000, made through the Manchester, Salford, and Stretford Joint Hospitals Board, the Department of Education for the Deaf at the University of Manchester has been helped to pursue its researches in the following directions:

(*a*) the continuance of investigations in the design and efficiency of individual and of group hearing-aids for adults and deaf children of school age;

(*b*) the provision of electro-acoustic equipment to enable totally deaf children to control the pitch of their voices by visual means;

(*c*) the investigation of methods of testing and measuring hearing in school children and adults.

The good work already done by the Department is well known. For instance, the use of hearing-aids in schools for the deaf was

begun as a result of early experiments made in the laboratories of the Department, and a clinic for the deaf has done outstanding work in alleviating deafness and in enabling sufferers to lead a more normal and useful life. To quote Sir John Stopford, Vice-Chancellor of the University: 'The Department has done magnificent work of a pioneer nature and no words can exaggerate my opinion of it.'

The design and material of orthopaedic appliances

Research into the design and material of orthopaedic appliances has been sponsored by the Trust on the application of a sub-committee of the British Orthopaedic Association set up to report on the development and supply of orthopaedic appliances. The Trust has made a grant of £4,000 to cover the cost of a two-year study of the design of orthopaedic appliances and the most suitable materials to be used in their manufacture. Mr. John Gull, an engineer, who was appointed to work under the direction of Mr. G. R. Girdlestone, F.R.C.S., and Mr. Norman Capener, F.R.C.S., has recently submitted an interim report on his work and, in the view of the sub-committee, has reached some interesting and valuable conclusions, in particular, on the design and supply of calipers. It has been suggested that further work should be on the design of appliances for patients suffering from paralytic lesions with special reference to the needs of sufferers from the 1947 poliomyelitis epidemic.

PENICILLIN RESEARCH

Towards the end of 1942 there was a doubt about the keeping together of the team of research workers in Oxford who, under the leadership of Professor Sir Howard Florey, M.A., M.D., PH.D., F.R.S., had been investigating during the previous three or so years the effects of extracts of *Penicillium notatum* in the cure of various bacterial diseases not only in animals but also in human beings. The therapeutic value of penicillin had been

recognized but it was thought to be essential that the clinical use of limited amounts should be carefully and skilfully controlled by experienced doctors at a small number of centres scattered throughout the country.

Early in 1943 the Trust undertook to make grants of £2,300 a year to guarantee for five years the salaries of Professor Florey's team of scientists. (This was done with the concurrence of the Medical Research Council, who had been supporting the work for several years and continued to make a substantial grant for research expenses.) The University of Oxford accepted these grants from the Trust with gratitude. Professor Florey's team then constituted a central unit recognized for two specific purposes:

'(i) To continue this extremely promising investigation of penicillin and other substances found in nature and of their influence on bacterial life, and

(ii) To control and co-ordinate the clinical trials of these substances in counteracting the effects of disease and injury; . . . without such co-ordinated use of hospital facilities further progress in research might well be delayed and the development of hospital therapeutic services seriously interfered with.'

Later in the same year the Trust offered the University a further grant of £1,000 a year until the end of the war, for the development of penicillin treatment of meningitis, brain abscesses, and other pyogenic diseases of the nervous system. The total amount of this second grant was £5,000.

NURSING AND OTHER AUXILIARY HOSPITAL SERVICES

It has long been recognized that the extension of hospital services is more limited by shortage of staff, both medical and nursing, than by the lack of buildings and beds; and the Trust, in making grants amounting to £32,000 for nursing purposes,

has always kept in mind the necessity for maintaining, and if possible increasing, the present nursing force.

To assist *recruitment* the Trust has made grants to extend to the provinces the work of the Centre established by the King Edward's Hospital Fund for London for the recruitment of nurses in the London area. It has also entirely financed, for an experimental period of three years, a similar centre in Scotland and is likely to continue its support for a further two or three years, by which time the Department of Health for Scotland may be able to take over.

Nursing education and training have been helped in a number of ways, more especially by the provision of scholarships—for nurses taking the teachers' certificate of the Scottish Board of the Royal College of Nursing; for nurses from provincial hospitals attending the Royal College of Nursing course in nursing administration in London and other senior courses of study; and for the postgraduate education of nurses in Northern Ireland.

Grants have also been made towards the development of training courses in industrial nursing in the provinces and in Scotland.

Hospital job-analysis

The Trust's latest attempt to help solve the difficult and stubborn problems raised by nursing recruitment and training takes the form of a complete job-analysis of the work of the nurse and of other members of the health team. The decision to sponsor such an investigation arose indirectly out of the publication, in 1947, of the Report of the Working Party appointed by the Ministry of Health to review the nursing profession. The Trust appointed a small committee, consisting of the principal of a large training college for teachers, an educational psychologist, a medical practitioner interested in nursing problems, and two experienced members of the nursing

profession, to study, under the chairmanship of the Secretary of the Trust, the Working Party's Report. The first, and one of the main conclusions reached, was that a long-term policy on nursing could not be settled until an answer was given to the question: 'What is the proper task of a nurse?' and that, to obtain the necessary data to answer this question, a complete job-analysis of the work of the nurse and other members of the health team was essential. The Trust decided to act on its own recommendation and the inquiry was started with the minimum of delay. It is far too early to comment on its progress, let alone to make so much as a guess at the conclusions it is likely to reach. All that can be said at the moment is that a pilot survey of a medium-sized hospital in the Home Counties has already been made and will form the basis for the main inquiry.

Within the hospital world, but outside the nursing field, the Trust has given its help in the way of training-grants for almoners and institutional domestic administrators, and has also interested itself in hospital dietetics and catering.

III

THE FUTURE PLANS OF THE TRUST

In the preceding section of this report an outline has been given of what has been attempted and accomplished in the past. On the future plans of the Trust it is not possible to be as precise as one might wish, but some indication of future aims and intentions is given in the following paragraphs.

The creation of the National Health Service introduced a situation differing widely from that which determined the Trust's activities hitherto. In consequence, the Trust was faced with two questions. First, did the creation of a national health service mean that the Trust's mission had been completed and that, thereafter, there would not be any useful work for it to do? If the answer to this question was in the negative, the second question arose—what work should the Trust undertake in future in pursuance of its trust objects, and what machinery would it need for this work?

The issue of whether or not the mission of the Trust has been completed or frustrated by the passing of the National Health Service Act is one of such importance that it may perhaps be useful to recapitulate briefly the facts at issue.

The purposes of the Trust are restricted to 'the co-ordination on a regional basis of hospital and ancillary medical services throughout the Provinces and the making of financial provision for the creation carrying on or extension of such hospital and ancillary medical services as in the opinion of the Governing Trustees are necessary for such co-ordination'. While, clearly, the betterment of the hospital and ancillary medical services was the underlying aim, the work undertaken by the Trust, and any schemes initiated by other bodies that it may finance, must be related to 'co-ordination on a regional basis'. Since the

National Health Service Act provides for the reorganization and full financial maintenance of the hospital services on a regional basis, there is no longer any need—as there was when the Trust was formed—for the Trust to organize and finance regional co-ordination between various elements of the hospital service. That responsibility now rests with the Government. In so far as there is still work for the Trust to do, such work will be related to two objects: (i) the betterment of regional co-ordination between those hospital and ancillary medical services provided for in the National Health Service Act, and (ii) the development and betterment of co-ordination on a regional basis (between themselves and in relation to hospitals) of those medical services ancillary to hospitals (e.g., industrial health services) to which the Act does not extend.

So far as the first object is concerned, it is already clear that the Government's acceptance of the principle of regional co-ordination of the hospital service, and the statutory reorganization of the service on that basis, still leaves unsolved a large number of problems for which an answer must be found before it can be claimed that a smoothly and efficiently working co-ordinated service is a fact. As for the second object, it is doubtful whether anyone would deny that the proper linkage to hospitals of the various ancillary services is a question bristling with a host of uncertainties and difficulties.

There is at present little practical experience to serve as a guide on many of these problems and it seems very doubtful whether, in a number of cases, the solutions will be found, still less fully applied, for some years to come. Careful study, but also practical experience, will be needed.

This is where the Trust expects to make its future contribution and that is why it does not hesitate in returning a negative answer to the first question posed by the creation of the National Health Service. As an independent body, which has shown in the past its capacity to co-operate fruitfully with Government agencies,

it possesses a standing, an objectivity, and freedom of approach, which give value to any studies or inquiries it may conduct or sponsor. The Trust has, in fact, recently embarked upon two such studies—the hospital job-analysis, to which reference has already been made in the preceding section, and an investigation into the functions and design of hospitals. If these two inquiries mature in anything like the way that is hoped, they should bring to light a volume of badly needed facts in a proved form, and should lead to constructive proposals for improvements. Before they are completed they may well demand the carrying out of some practical experiments.

The experimental mobile meals service which the Trust, in co-operation with the Essex County Council and the Thurrock Urban District Council, has recently established in Thurrock, Essex, is intended to provide an example of co-ordination between hospital, general practitioner, and local health authority services. Under this scheme, meals—cooked in the kitchen of the local hospital and specially prescribed when necessary—are delivered on medical recommendation to invalids, convalescents, and feeble old people in their own homes. It is hoped that the scheme, supplementing the domiciliary nursing facilities provided by the local health authority, will indicate one of the ways in which existing pressure upon hospital beds and services may be relieved.

The Trustees have now, in short, reached the following conclusions:

(i) That, notwithstanding the changes brought about by the National Health Service Act, the Trust still has plenty of work to do.

(ii) That, for the stage which can now be foreseen and for which plans can be made, the work of the Trust can be summed up in three words: study, experiment, and demonstration. First, the fullest scientific study of the hospital and ancillary medical services. Next, the conduct of practical

experiments when they appear necessary as a means of finding the true facts or of testing promising ideas. Third, the demonstration of new methods believed to be an improvement on the old, as being often the quickest way to gain their acceptance. Sometimes these studies, experiments, and demonstrations may be conducted directly by the Trust. More often, they will be conducted by other bodies with the financial support of the Trust.

At the same time it is hoped that the Trust may find opportunities to assist the search for means of securing that new knowledge gained by medical science is given general application in the shortest possible time. Any reduction in the long time-lag which has existed in the past would be a gain to humanity.

The proposed reorientation of the policy and activities of the Trust will necessitate certain alterations in the administrative and advisory machinery of the Trust, and these are now under way.

APPENDIX I

Extract from 'A National Hospital Service, A Memorandum on the Co-ordination of Hospital Services', by the Medical Advisory Council of the Trust, published in 1941

OVER a number of centuries voluntary hospitals were established and largely maintained for the sick and injured poor by charitable and generous members of the community, the treatment of their patients being undertaken by the medical profession without payment. These hospitals were erected here and there without any organized planning, with the result that they are unequally distributed and practically unrelated to one another either geographically or administratively. Within recent years the number of hospitals has been added to by local authorities who are empowered to provide medical care and treatment for persons resident within their areas. It is important that this development should be carefully planned, with due attention to economy and to the needs of the population, in which connexion Regional Councils, when established, should be of the greatest help.

During recent years, there has been a rapidly spreading tendency on the part of the public to seek help from hospitals in time of sickness or injury, and practically all classes now expect such help in return for smaller or larger payments or contributions. The reasons for this change are easily exposed. With the advance of medical knowledge methods of diagnosis and treatment have become so much more expensive and so much more specialized that many of them are not readily available except in institutions. Moreover, social and domestic conditions have altered with the result that many households are unable to stand the strain of long illnesses and skilled nursing at home. Regional Councils will need to face this problem, recognizing that it will grow rather than dwindle in the future and that hospital development must provide for the accommodation of patients varying over a wide income range.

This increase in the scope and utility of hospital work has many repercussions. It is essential, on economic grounds, to centralize

the more expensive and more specialized methods of investigation and treatment in the larger hospitals and, at the same time, to make them accessible, in case of need, to every doctor and patient within the Region. The solution of this dual problem is an implicit obligation laid on Regional Councils and one which must involve some radical changes in hospital organization and in the economic position of the medical profession.

The co-ordination of voluntary and local authority hospitals in regard to the medical services they provide for the public is a matter of great importance and every effort should be made to co-ordinate the two. There are several factors which have hitherto made such co-ordination difficult. The local authorities, for instance, are obliged by statute to recover from their patients the cost of treatment, or such part (if any) as they are able to pay, including payments through a contributory scheme. The voluntary hospitals, on the other hand, rely on less stringent methods of assessment and recovery, such as the contributory schemes or a voluntary assessment by a hospital almoner. Some progress has been made in overcoming these difficulties, notably in Merseyside, and the appointment of almoners, a principle at present adopted by very few local authorities, by municipal as well as by voluntary hospitals and the submission by voluntary hospitals to more uniform methods of assessment would help towards the solution of the problem.

Regions cover wide areas containing populations which vary in size and, under the scheme envisaged, are broken up into two or more Divisions in accordance with the distribution of the hospitals and of the population within the Region. The primary or key hospital or group of hospitals of the Region should be, if possible, one connected with a medical school, staffed and equipped to undertake all general and special hospital work and capable of offering both advisory and practical assistance to institutions within the Region less completely provisioned. The key hospital of the Region will naturally be the key hospital of the Division in which it lies. The key hospital of other Divisions will generally be a large non-teaching hospital which again will be linked to the smaller hospitals of the Division by means of organized services. There should be a system of interchange between key and secondary hospitals, patients requiring special investigation or treatment being transferred from the secondary to the key hospitals, involving the organization of trans-

port services, while patients already investigated and whose condition permits of treatment in a secondary hospital should be transferred to such a hospital in the neighbourhood of the patient's home. Such a system would prove economical to patients and would relieve the waiting-lists of the key hospitals.

In the organization of medical services some of the smaller or cottage hospitals without a resident medical officer present a difficult problem. It is to be hoped that hospitals with less than twenty beds can be usefully included in a co-ordinated scheme and be worthy of regional support if used for suitable purposes, such as ear, nose, and throat, dental and school clinics, and convalescent accommodation. In many Regions there are scattered about small hospitals of not more than fifty beds and without resident medical staff which should be linked up with the key hospitals by means of an agreement that they should undertake the care of patients from their neighbourhood who do not need more special skill than can be obtained by visits of specialists from the centre and of patients who are ready to leave the key hospital and are not yet fit to return to their homes. It should be a condition of the recognition of such hospitals that the general practitioners who staff them should welcome the addition to their number of one or more consultants paying regular visits and should undertake to keep adequate records of cases under their care, in conformity with a system of record-keeping adopted by the Region on the advice of the Medical Advisory Committee. This condition is important for the progress of medical science and should facilitate field research work undertaken at the centre of the Region.

The linking of key hospitals with general hospitals of over fifty beds with one or more resident medical officers by means of a system of periodic visits by the consulting staff associated with the key hospital would be one method of bringing the general practitioner into closer contact with the key hospital and thus enable him to keep pace with advancing knowledge. Another step directed towards the same object would be the organization of special services. Examples of these are . . . pathological and accident services. . . . Still further means of absorbing general practitioners into the co-ordinated scheme would be provided by clinical assistantships in the larger hospitals and by postgraduate conferences and courses of instruction undertaken by the key hospital of the Region.

The development of organized medical services has been delayed

by lack of any regional hospital scheme in the past, with the result that progress in medical knowledge and skill has outrun any measures taken for their widespread application.

The distribution of consultants and specialists has been extremely unequal: in some Regions there are many, even if not enough; in others very few or none. But even where there are many in a key centre they should in the future extend their activities thence to a personal share in the work of smaller hospitals where there is a shortage. The staffs of large hospitals will need to be increased if they have the responsibility of visiting outlying institutions and, in some cases, have charge of beds in them. In some areas it may be advisable for consultants to be nominally on the staff of a key hospital but to reside in an outlying area and serve a group of small hospitals.

It is quite conceivable that the co-ordination scheme will ultimately involve the appointment of doctors to a Region, or to a group of hospitals within a Region, rather than to individual hospitals, so that each member of the staff of a Region may eventually carry out the work for which his abilities and experience most suit him, whether it be general consulting practice, one of the specialties, teaching, or research. In these ways increments of medical knowledge may be more easily and quickly and skilfully applied to the general practice of the profession. Moreover, it may be submitted with some confidence that with a recognition of the value of a wider distribution of specialist work, more men and women with the ability and qualifications to perform consultant and specialist services would be attracted to these branches of the profession, provided that they could depend on equitable payment from some source or another.

All the changes envisaged in regard to institutional treatment for patients of all classes point to the conclusion that the voluntary hospitals were not intended to meet the increased medical and health needs of the population. This fact was recognized by the State in the Local Government Act of 1929 with the result that there are now more hospital beds in the country in municipal than in voluntary hospitals. It is essential that the system of staffing all these hospitals, both municipal and voluntary, should be unified, a step which involves the remuneration of hospital medical staffs on a similar basis throughout the country as well as the measures in regard to the distribution of staff already referred to.

APPENDIX 2

Regional and Divisional Hospitals Councils set up or 'recognized' by the Trust

ENGLAND

North-Eastern Regional Hospitals Advisory Council for Northumberland, Durham, and the Cleveland area of the North Riding of Yorkshire.

Divisional Committees for

(i) Tyneside, Northumberland, and North-West Durham;

(ii) Sunderland and Hartlepools;

(iii) Tees-side.

Berks., Bucks., and Oxon. Regional Hospitals Council for the three counties.

Divisional Councils for

(i) Bucks. and East Berks.;

(ii) Reading and District;

(iii) Oxford and District.

South-Western Regional Hospitals Council for Cornwall, Devon, and the Isles of Scilly.

Divisional Councils for

(i) Cornwall and the Scilly Isles;

(ii) Devon;

(iii) Plymouth.

Yorkshire Regional Hospitals Council for the North Riding (excluding the Cleveland area), East Riding, and West Riding (excluding the area south of a line east and west through Barnsley).

Bristol Divisional Hospitals Council for the city and the areas contiguous to the periphery.

Surrey Hospitals Divisional Council.

SCOTLAND

Scottish Advisory Committee.

NORTHERN IRELAND

Northern Ireland Regional Hospitals Council.

JOINT COUNCILS 'RECOGNIZED' BY THE TRUST

Birmingham Hospitals Council.
Essex Hospitals Joint Advisory Council.
Liverpool Hospitals Joint Advisory Committee.
Manchester, Salford, and Stretford Joint Hospitals Advisory Board.
Sheffield Municipal and Voluntary Hospitals Joint Committee.
West Midland Hospitals Joint Advisory Council.
Gloucester County and City Joint Hospitals Consultative Committee.

APPENDIX 3

Hospital Survey: a list of the surveys initiated by the Trust, the Ministry of Health, and the Welsh Board of Health

(INITIATED BY THE TRUST)

Survey Area	*Surveying Officers*
North-Eastern	Sir Hugh Lett, Bt., C.B.E., F.R.C.S. A. E. Quine, Esq., M.B., CH.B., F.R.C.S., D.P.H.
Yorkshire	Sir Herbert Eason, C.B., C.M.G., M.D., M.S., F.R.C.S. R. Veitch Clark, Esq., M.A., B.SC., M.B., CH.B., D.P.H.
Eastern	Sir William G. Savage, M.D., B.SC., D.P.H. Sir Claude Frankau, C.B.E., D.S.O., M.S., F.R.C.S.
Sheffield and East Midland	Professor Sir Leonard Parsons, M.D., F.R.C.P. S. Clayton Fryers, Esq., C.B.E., F.H.A. G. E. Godber, Esq., D.M., F.R.C.P., D.P.H.
South-Western	V. Zachary Cope, Esq., M.S., M.D., F.R.C.S. W. J. Gill, Esq., M.D., F.R.C.S. Arthur Griffiths, Esq., O.B.E., F.H.A. G. C. Kelly, Esq., B.SC., M.D., D.P.H.
Berks., Bucks., and Oxon.	E. C. Bevers, Esq., M.A., F.R.C.S. Professor G. E. Gask, C.M.G., D.S.O., F.R.C.S. Professor R. H. Parry, M.D., F.R.C.P., D.P.H.
West Midlands	John B. Hunter, Esq., M.C., M.A., M.CH., F.R.C.S. R. Veitch Clark, Esq., M.A., B.SC., M.B., CH.B., D.P.H. Sir Ernest Hart, M.B.E.

Northern Ireland	Stanley Barnes, Esq., M.D., D.SC., LL.D., F.R.C.P. Sir William P. MacArthur, K.C.B., D.S.O., O.B.E., M.D., D.SC., F.R.C.P. Duncan G. Leys, Esq., D.M., F.R.C.P.

(INITIATED BY THE MINISTRY OF HEALTH)

London and the Surrounding Area	Sir Archibald M. H. Gray, C.B.E., M.D., F.R.C.P., F.R.C.S. Andrew Topping, Esq., M.D., F.R.C.P., D.P.H.
North-Western	Sir Ernest Rock Carling, F.R.C.S., F.R.C.P. T. S. McIntosh, Esq., M.A., M.D., F.R.C.P. (Ed.), D.P.H.

(INITIATED BY THE WELSH BOARD OF HEALTH)

South Wales and Monmouthshire	A. Trevor Jones, Esq., M.D., M.R.C.P., D.P.H. Professor J. A. Nixon, C.M.G., B.A., M.D., F.R.C.P. Professor R. M. F. Picken, M.B., CH.B., B.SC., D.P.H.

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